

INDIANA STATE DEPARTMENT OF HEALTH
Division of Long Term Care

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TITLE: REPORTABLE INCIDENTS POLICY [This policy was formerly referred to as the ISDH Reportable Unusual Occurrence Policy.]

PURPOSE: To ensure that reportable incidents are recorded and monitored to facilitate compliance with state and federal laws.

POLICY: All incidents reported to the Indiana State Department of Health will be recorded and tracked or monitored to insure residents are receiving appropriate care and services.

PROCEDURE:

I. Reportable Incidents

Facilities are required by law to report incidents within 24 hours of occurrence to the Long Term Care Division. CFR 483.13(c)(2) states:

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency).

The following are examples of incidents that the Long Term Care Division considers reportable under both State Rule and Federal Regulation. These incidents will be reported by facility and will be tracked and monitored.

(1) ABUSE - Physical, Sexual, Verbal and/or Mental (known and/or alleged)

Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish.

- (A) **PHYSICAL ABUSE** – includes, but not limited to, hitting, slapping, pinching, and corporal punishment.
 - 1) Resident to resident abuse with or without injury;
 - 2) Staff to resident abuse with or without injury;
 - 3) Other (visitor, relative) to resident abuse with or without injury.
- (B) **SEXUAL ABUSE**
 - 1) Staff to resident;
 - 2) Resident to resident non-consensual sexual acts;
 - 3) Resident to resident - sexual acts when both parties are considered mentally incompetent or dependent, and injury is sustained;
 - 4) Other (visitor, relative) to resident non-consensual sexual acts.
- (C) **VERBAL ABUSE** – is defined as the use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident; telling a resident that he/she will never be able to see family again; belittling residents.
 - 1) Staff to resident - any episode;
 - 2) Resident to resident verbal threats of harm.
- (D) **MENTAL ABUSE** – includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.
 - 1) Staff to resident - any episode
- (2) **NEGLECT** – failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.
 - Failure to provide goods and services which has resulted in resident negative outcome
- (3) **INVOLUNTARY SECLUSION** – is defined as a separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.
- (4) **UNUSUAL DEATH**
 - A) death of a resident that is unusual and/or the result of an accident;
 - B) any violent or suspicious death which has been reported to the coroner.

(5) INJURIES OF UNKNOWN SOURCE

An injury should be classified as an *injury of unknown source* when both of the following conditions are met:

- (A) the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and
- (B) the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

(6) SIGNIFICANT INJURIES

- A) Examples, but not inclusive of all:
 - 1) injuries sustained while a resident is physically restrained;
 - 2) large areas of contusions or large lacerations as defined in facility policy;
 - 3) fractures sustained by a totally dependent resident (as defined on MDS);
 - 4) burns greater than first degree;
 - 5) serious unusual and/or life threatening injury;
 - 6) choking requiring hospital treatment.
- B) Medication errors that caused resident harm or require extensive monitoring for 24-48 hours.

(7) RESIDENT ELOPEMENT

- A) A cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown;
- B) Any circumstance of elopement which required police notification.

(8) EPIDEMIC OUTBREAK AND/OR, QUARANTINE

Disease incident rate that is greater than the established baseline, based on facility infection control policy.

(9) POISONINGS AND/OR BIO TERRORISM ACTS

(10) UTILITY INTERRUPTION

- A) An interruption of more than four (4) hours in length in one or more major utilities to the facility, (such as fire alarm, sprinkler system, phone services, electrical, water supply, plumbing, i.e., sewage disposal/backup, heat or air conditioning);
- B) Any interruption of utility services due to non-payment.

(11) STRUCTURAL DAMAGE

Structural damage to building due to natural disasters such as tornadoes, flooding, earthquakes, or catastrophes.

(12) ABANDONMENT

Employee(s) that walks off the job leaving residents unattended which results in the facility being unable to adequately care for the residents needs and the resident(s) are in jeopardy.

(13) MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY

Misappropriation of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The report must be submitted within 24 hours after the preliminary investigation has determined that resident property or funds have been misappropriated.

(14) WIDESPREAD RODENT AND/OR INSECT INFESTATIONS

(15) FIRES – within facility due to any cause.

II. FACILITY REPORTING AND INVESTIGATION INSTRUCTIONS:

Facility must contact the ISDH by telephone (317/233-7442), voice mail for incidents during business hours (317/233-5359), fax (317/233-7494) or e-mail (incidents@isdh.in.gov) within 24 hours upon determining a situation exists (or existed) that is reportable under these guidelines. The after hours telephone number is 317/233-8115. A blank *Incident report form*, which can be utilized to report incidents, is available on the ISDH web site at www.in.gov/isdh/regsvcs/providers/contact.htm.

The initial report should contain:

- (A) a brief description of the occurrence;
- (B) any injury sustained by a resident;
- (C) a description of the action taken by the facility to respond to the situation;
- (D) action taken by the facility to prevent further occurrence while the investigation is in process.

A five (5) day follow-up report is required to include the following:

- (A) results of investigation;
- (B) plan of action/interventions implemented to prevent similar occurrences; to include corrective actions taken;
- (C) method in which facility will continue to monitor efficacy of interventions;
- (D) other persons or agencies to whom incident was reported, e.g., Adult Protective Services, police, etc.

If the above eight (8) points have already been included in the initial report, a five (5) day follow-up report is not necessary. This original report must indicate that it is both the initial and follow-up report.

Each incident will be entered into the ISDH Long Term Care database.

The ISDH may call for further information.

Each incident will be reviewed and/or investigated during a survey.



Kim Rhoades
Director, Division of Long Term Care



Date